Laura Stevenson, RMT

Confidential Client Information and Health History Form

Name: _____ Date of Initial Visit: _____

Address: _____ City _____ Postal Code: _____

Date of Birth: (MM/DD/YYYY): _____ Email: _____

Home: ( ) _____ Cell: ( ) _____

Appointment Reminders: ☐ Email ☐ Text ☐ Both

Occupation: _____

Physician Name and Telephone #: _____

Emergency Contact/ Relationship/ Phone #: _____

Which treatment modalities have you received previously:

Massage ☐ Chiropractic ☐ Acupuncture ☐ Orthotics ☐ Physiotherapy ☐ Other ☐

How did you hear about Laura Stevenson, RMT: _____

List of Medications/ Supplements: _____

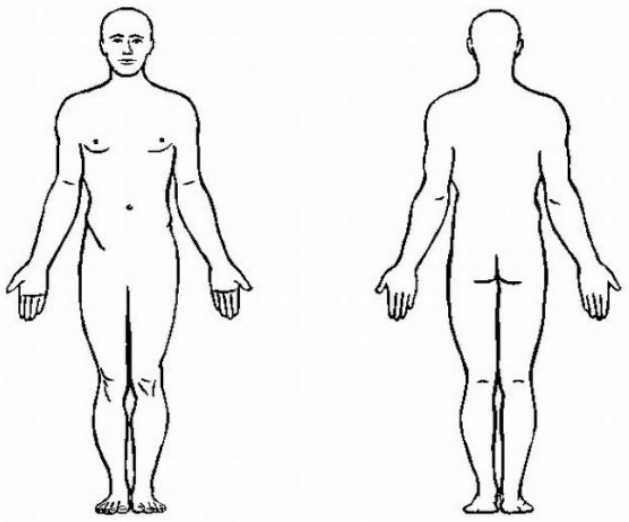
_____

Any medications taken today (other than above)? Yes ☐ No ☐ If yes, what and how long ago?

_____

Please mark on diagram and/or list the issues that bring you in today:

-
-
-
-
-



How would you rate your pain? no pain 0, extreme pain 10:

Is it consistent ☐ frequent ☐ occasional ☐ infrequent ☐

Does it travel/move around? Yes ☐ No ☐

What relieves your pain? _____

What aggravates your pain? _____

Please check what applies to you regarding your health history, past and current or family history:

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ congestive heart failure
- ☐ heart attack
- ☐ phlebitis/ varicose veins
- ☐ stroke/aneurysm, cerebrovascular event
- ☐ pacemaker or similar device
- ☐ heart disease
- ☐ high cholesterol
- ☐ anemia
- ☐ varicose veins
- ☐ phlebitis
- ☐ edema/swelling
- ☐ hemophilia

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema
- ☐ sinus issues

Head/Neck
- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems/ loss
- ☐ ear problems
- ☐ earaches/ringing in ears
- ☐ hearing loss
- ☐ whiplash

Infections
- ☐ hepatitis (A/B/C)
- ☐ TB
- ☐ HIV/ AIDS
- ☐ herpes
- ☐ plantar warts
- ☐ polio
- ☐ eczema/ psoriasis
- ☐ pelvic inflammatory disease
- ☐ skin conditions: _____

Multiple Body Systems
- ☐ kidney disease
- ☐ bladder issues
- ☐ liver/ gall bladder
- ☐ Crohns/ colitis
- ☐ fibromyalgia
- ☐ multiple sclerosis
- ☐ scoliosis
- ☐ irritable bowel
- ☐ ulcers
- ☐ digestive issues
- ☐ bruises easily
- ☐ osteoporosis/ osteopenia

Other Conditions
- ☐ loss of sensation, where? _____
- ☐ diabetes, type, onset _____
- ☐ allergies/ hypersensitivity to what? _____
- ☐ type of reaction _____
- ☐ cancer, where? _____
- ☐ pins, rods, artificial joints _____
- ☐ epilepsy
- ☐ arthritis (osteo./rheumatoid)
- ☐ fainting/ dizziness
- ☐ alcohol consumption (___/week)
- ☐ smoker (current/past)

Mental Health
- ☐ ADHD
- ☐ anorexia nervosa
- ☐ anxiety
- ☐ bipolar
- ☐ bulimia
- ☐ chronic fatigue
- ☐ depression
- ☐ OCD
- ☐ PTSD
- ☐ sleep disturbances
- ☐ stress
- ☐ Other: _____

Women
- ☐ Pregnant, due: _____
- ☐ Gynecological conditions, what? _____
- ☐ Do you suffer from PMS: ☐ Yes / ☐ No
- ☐ Are you taking oral contraceptive (OCP): ☐ Yes / ☐ No
- ☐ Other form of birth control _____
- ☐ Menopause (Current or Past)_____

Is your current injury/complaint the result of a:

MVA/car accident? □ WSIB/WSCC/workplace injury? □

Do you currently exercise? Yes □ No □ If yes, how often in hrs./week: _____

List your sports and activities: _____

Have you had any serious or chronic illnesses in the past? Yes □ No □

If yes, what and when: _____

Have you had any fractures/sprains in the past? Yes □ No □

If yes, where and when: _____

If you have hand ANY other injury/accident, please state the date & specific nature of the injury/accident:

_____

_____

If you have ever had any surgical procedure, please state the date & specific nature of that surgery:

_____

_____

Signature of Patient (or Guardian): _____ Date: _____